Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

Respondent Name

TRAVELERS PROPERTY CASUALTY CO

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-07-0341-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As you know, my client billed total charges of $470,607.25, of which your company paid approximately 70%. However, given the severity of this patient's medical condition and the extensive nature of the services and supplies provided, my client feels that it is entitled to additional payment on this claim and that a 30% discount herein is unwarranted. In order for my client to be reimbursed at a fair and reasonable rate, it is requesting that its usual and customary charges be paid for this major trauma victim. Accordingly, my client expects to receive an additional payment of $141,547.92, plus interest on this claim."

Amount in Dispute: $141,547.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated September 27, 2006: "The hospital bill was reduced to fair and reasonable along with an additional reduction of charges due to a negotiated discount obtained through Concentra Preferred Systems."

Respondent's Supplemental Position Summary dated March 6, 2012: "Upon receipt of the billing, the Carrier's bill processing vendor contacted the Provider. They spoke with Connie Campbell…The Provider's representative and the Carrier's vendor negotiated an agreed reimbursement that both parties believed was fair and reasonable given the nature of the services at issue. Based on that negotiated agreement, the Carrier reimbursed the Provider $329,059.33 on the original billed charges of $470,607.25. This represents the 70% of billed charges negotiated with Ms. Campbell…Subsequently, in violation of that agreed amount, the Provider filed this Request for Medical Fee Dispute Resolution."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 2005 through October 26, 2005	Inpatient Services	$141,547.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on September 13, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 21, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated December 20, 2005
   - DOP-W10-No maximum allowable defined by fee guideline. Reduced to fair & reasonable. No MAR has been set by TWCC in the medical fee guideline.
   - IMPL-16-Claim/Service lacks information which is needed for adjudication, add'l information is supplied using remittance advice remarks code. Not documented. Invoice needed.
   - CNEG-131-Claim specific negotiated discount. Reduction of charges was applied due to a negotiated discount obtained through Concentra Preferred Systems.

   Explanation of Benefits dated July 31, 2006
   - W10-No maximum allowable defined by fee guideline. Reduced to fair & reasonable. No MAR has been set by TWCC in the medical fee guideline.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration. After carefully re-viewing the resubmitted invoice, additional reimbursement is not justified.
   - 16-Claim/Service lacks information which is needed for adjudication, add'l information is supplied using remittance advice remarks code. Not documented. Invoice needed.
   - 131-Claim specific negotiated discount. Reduction of charges was applied due to a negotiated discount obtained through Concentra Preferred Systems.
   - 45-Charges exceed your contracted/legislated fee arrangement, the difference between the fee schedule amount and the amount paid is your PPO discount.

Findings

1. According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Texas Labor Code §413.011(d-3) states that the division may request copies of each contract under which fee are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On February 17, 2012, the division requested a copy of the contract between the network and the health care provider. The carrier failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed in accordance with the applicable division rules and fee guidelines.
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 801.20. The Division therefore determines that this inpatient admission

shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "As you know, my client billed total charges of $470,607.25, of which your company paid approximately 70%. However, given the severity of this patient's medical condition and the extensive nature of the services and supplies provided, my client feels that it is entitled to additional payment on this claim and that a 30% discount herein is unwarranted. In order for my client to be reimbursed at a fair and reasonable rate, it is requesting that its usual and customary charges be paid for this major trauma victim. Accordingly, my client expects to receive an additional payment of $141,547.92, plus interest on this claim"
   - The requestor does not discuss or explain how additional payment of $141,547.92 would result in a fair and reasonable reimbursement.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		3/22/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		3/22/2012
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.